

PART I: GENERAL INFORMATION

Type of Requestor:	(x) HCP	() IE	() IC	Response Timely Filed?	(x) Yes	() No
Requestor's Name and Address Vista Medical Center Hospital 4301 Vista Road Pasadena, Texas 77504				MDR Tracking No.:	M4-03-7429-01	
				TWCC No.:		
				Injured Employee's Name:		
Respondent's Name and Address Transcontinental Insurance Company C/O Stone Loughlin & Swanson, LLP P O Box 30111 Austin, Texas 78755 Box 06				Date of Injury:		
				Employer's Name:	Waste Recovery, Inc.	
				Insurance Carrier's No.:	35501153	

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
05/18/02	05/22/02	Surgical Admission	\$59,089.17	\$0.00

PART III: REQUESTOR'S POSITION SUMMARY

“In this instance, the audited charges that remained after the last bill review by the insurance carrier were \$80,276.22. The prior amounts paid by the carrier were \$1,118.00. Therefore, the carrier is required to reimburse the remainder of the Workers’ Compensation Reimbursement Amount of \$59,089.17, plus interest.”

PART IV: RESPONDENT'S POSITION SUMMARY

“Provider submitted a preauthorization request for inpatient surgery, 1 day stay, consisting of a posterior lumbar fusion at L5-S1, which was approved on April 30, 2002. On May 18, 2002, Claimant was admitted to Hospital for the surgery which was performed that day by surgeons. Two days after the surgery, on May 20, 2002, Provider submitted a preauthorization for an extension of the length of stay through May 23, 2002. The request was denied due to lack of medical necessity. The claimant should have been discharged on 05/19/02. The claimant was discharged from the hospital on May 22, 2002.”

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested additional reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for “unusually costly services.” The explanation that follows this paragraph indicates that in order to determine if “unusually costly services” were provided, the admission must not only exceed \$40,000 in total audited charges, but also involve “unusually extensive services.”

The carrier submitted evidence that the provider only obtained preauthorization for a 1-day stay for the services rendered. The carrier denied the preauthorization for the extension submitted by the provider. The carrier made reimbursement based on per diem in the amount of \$1,118.00.

After reviewing the information provided by both parties, it does **not** appear that this particular admission involved “unusually extensive services.” The operative report indicates that this was a posterior lumbar fusion. The operative report also indicates the patient was sent to the recovery room in satisfactory condition and no complications were noted in the operative report. Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

The carrier made reimbursement for the 1-day stay in the amount of \$1,118.00.

The requestor billed \$14,846.00 for the implantables and the carrier made no reimbursement. The requestor did not submit an invoice indicating the cost for the implantables. Therefore, MDR cannot determine the cost of the implantables and no reimbursement is recommended for the implantables.

Therefore, based on the facts of this situation, the parties' positions, and the application of the provisions of Rule 134.401(c), we find that the health care provider is not entitled to additional reimbursement.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor **is not** entitled to additional reimbursement.

Ordered by:

Michael Bucklin

07/12/05

Authorized Signature

Typed Name

Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787 Austin, Texas 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____